The genitourinary physician and AIDS

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Abstract

The arrival of AIDS/HIV infection in the UK has conferred a new significance upon genitourinary medicine which is necessarily involved in all aspects of patient care, surveillance and prevention. HIV should now be considered a relevant issue for discussion with all presenting patients who are at-risk of contracting any sexually transmitted disease. Targetting education at individuals together with the successful implementation of other control strategies through genitourinary medicine clinics provides exceptional opportunities to inhibit the further spread of HIV infection and to reduce morbidity from other STD and related pathology in the wider community.

The advent of antibiotic therapy in the post war period changed the nature of clinical practice in sexually transmitted diseases (STD). As treatment courses and follow-up became shorter, and patients could be reasonably assured of full restoration to health, management became almost wholly outpatient based. The simple treatment schedules belied a sophisticated and advanced management approach. Increased emphasis was placed upon disease detection and prevention. Health education of young people in schools and one-to-one discussion with patients in the non-judgemental clinic setting, combined to promote personal awareness of STD and was an important adjunct to effective treatment. Early attendance, comprehensive screening of those who perceived themselves "at-risk", laboratory methods which increased speed of diagnosis, and effective contact tracing combined to control prevalence.[1] By reducing the incidence of potentially devastating complications of STD they also proved cost-effective.[2] In spite of these successes in the UK, the STD services were regarded as a low health-care priority and were ill-prepared to meet the increased workload imposed by the changes in sexual mores during the sixties and seventies. The lack of resources posed an increasing and real threat to the acceptability and accessibility of clinics.[3]

All that has changed. The fortunes of genitourinary medicine have dramatically improved with the appearance of AIDS/HIV infection. Its arrival in the UK has bestowed a new prominence upon the specialty and brought new resources in recognition of genitourinary medicine's pivotal role in its care and prevention.[4]

CARE OF THE HIV POSITIVE PATIENT

From the onset of the epidemic, genitourinary medicine has been intensely involved in the diagnosis and care of HIV infected patients because of the long standing rapport between the clinics and homosexual/bisexual men. As expected, the Thames Regions gained early clinical exposure to HIV infection. A developing expertise in the management of HIV-related disorders ensued. It rapidly emerged that patients required multidisciplinary inpatient care. New partnerships with a variety of allied specialties have resulted.

This pattern of inpatient care has evolved in different ways in different localities and is dependent upon such factors as the availability of beds, junior staff, and the interest and expertise of allied disciplines. In some hospitals genitourinary physicians have taken prime responsibility, in others there has been shared care, whereas elsewhere inpatient care has been primarily the responsibility of other specialists. As the threat of AIDS/HIV infection grows, genitourinary physicians' responsibilities and commitments will increase. The Specialty Advisory Committee in Genitourinary Medicine requires senior registrars to be fully trained in all aspects of HIV management.[5] Their involvement in on-call arrangements for AIDS inpatients is inevitable and desirable.

Outpatient care must be long-term in outlook. The initial disclosure of a positive test result is undeniably traumatic and often devastating. Nevertheless, effective counselling and support can enable many HIV positive individuals to develop a new sense of pur-

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pose and well-being. Many will accept responsibility for their own and their partners health; hence early diagnosis will help to prevent further transmission of HIV.

Out-patient care must also include clinical, virological and immunological monitoring aimed at early recognition of disease progression which allows the early commencement of antiviral treatment together with prophylaxis of opportunistic infections. Zidovudine, whilst not being a curative treatment, is an important advance in therapy. There is increasing evidence of lowered toxicity and increased benefits to immunocompromised patients when treatment is initiated prior to the onset of end-stage disease.[6] Many genitourinary physicians already participate in the MRC-INSERM Concorde 1 study to investigate whether zidovudine will reduce the risk of disease progression in asymptomatic infected individuals. This national network of participating centres also provides the potential means for evaluating other new strategies in treatment and prophylaxis. Demands on genitourinary physicians in this area can be expected to increase.

SURVEILLANCE

The long-established British Cooperative Clinical Group (BCCG) of genitourinary physicians has conducted a survey of homosexual/bisexual clinic attenders during the three year period 1986–88 (unpublished data). In the final quarter of 1988, 122 (8·5%) of 1,433 susceptible men had newly diagnosed HIV infection. The overall UK prevalence of HIV infection in all tested homosexual/bisexual men attending in this period was 41%; in some of the Thames Regions it was over 60%. The selection of HIV seropositives for continuing care inevitably introduces a bias to the BCCG survey results; point prevalence studies at the Middlesex Hospital show a lower seropositivity rate amongst homosexual/bisexual men rising from 4% in 1982 to 26% in 1987.[7] Clearly the time when the HIV problem could be considered to be a problem peculiar to London has long passed. Viewed nationally, of 1,078 seropositive attenders, 20% had AIDS, 16% other CDC Group IV disease, 17% persistent generalised lymphadenopathy 17%, and the other 47% were asymptomatic.

Despite a falling incidence of gonorrhoea and syphilis during the BCCG study period, the prevalence of other STD in gay men remained unchanged at 30%. For many their change in sexual behaviour has come too late to prevent their acquiring HIV infection. Others are still manifestly failing to adopt safe sexual practises which would protect them against all STD.

A worrying feature in this study was the decreasing acceptance of HIV testing by susceptible attenders which denies both the patient and their consorts the potential advantages of early diagnosis.[7] Consent to screening was given by less than one third of attenders in Thames as compared with two thirds of attenders in the North and Midlands. Undoubtedly, acceptance of HIV testing has been adversely affected by publicity about the consequences when testing has been performed by those inadequately prepared to support and counsel the positive patient. Clearly, HIV testing should only be performed by those with the necessary resources of time and personnel who accept, from the outset, the obligations to the patient of confidentiality and long term care. The new resources directed at genitourinary clinics should permit all genitourinary physicians to accept these commitments unreservedly.

Genitourinary physicians have an important monitoring role. They alone can provide a sensitive indicator of the sexual spread of infection. There has been an ongoing national collaborative study involving genitourinary physicians and the Public Health Laboratory Service since 1985.[8] Up until 1988, it appeared that almost all HIV positive heterosexuals were either IVDA, known consorts of at-risk patients, or had been heterosexually infected abroad. However, there have been recent signs of heterosexual acquisition outside these groups in both London and provincial teaching centres.

PREVENTION

The reported fall in heterosexual attendances at STD clinics, following the initial national AIDS information campaigns, has been small.[9] The majority of clinic patients still do not perceive HIV to be an issue which concerns them. However, the prevalence of HIV seropositivity in homosexual men was high before overt AIDS cases appeared;[10] observed changes in sexual behaviour were a reaction to the latter. To prevent a repetition of this experience within the larger heterosexual community, those who are at greatest risk of sexual acquisition of HIV—that is, those who are currently acquiring other STD—should be targeted for intensive educational efforts. The current low incidence of AIDS in heterosexuals has promoted a false security, to counteract which education must remain our major tool.

The acknowledged importance of other STD, especially genital ulceration, as co-factors in the acquisition and transmission of HIV,[11,12] argues for a strengthening of all modalities of STD control to prevent AIDS spread. Many genitourinary physicians now believe that active case finding methods should be applied equally to HIV/AIDS. The argument that HIV infection is different from other STD is spurious. That it is life-threatening should heighten rather than diminish control efforts. Discussion of HIV/AIDS and the offer of HIV antibody testing should now become a routine part of the genitourinary medicine consultation. Whilst patient consent to testing must remain a prerequisite, a

decision to refuse testing should follow rather than precede information about the issues. The patient clearly at risk for HIV infection who refuses testing is no less in need of repeated counselling.

This necessitates that all members of the clinical team accept a role in health education. Consultants have the responsibility to ensure that there is compatibility in the approach and accuracy in the context of advice given by each member of the team. If genitourinary medicine is to continue to give a lead in HIV prevention, we should avoid biased or negative counselling. Equally as bad for control is failure to raise HIV as a relevant issue for every patient. We must not lose our invaluable opportunity to target education to the at-risk heterosexual *individual*. These approaches are more likely to have an impact upon attitudes and behaviour than public campaigns generally directed to ill-defined risk groups.

It is also vital that prostitutes be encouraged to attend for regular check-ups for STD and to use condoms. Health advisers and AIDS counsellors have an important role in instituting health education for these individuals. Establishing a good rapport and extending a welcome to persons whose lifestyle places them at high risk of STD/HIV is imperative and can be combined with other health promoting activities such as hepatitis B immunisation and screening for early genital neoplasia. The genitourinary physicians must ensure that their service is acceptable to those most in need of it. Monitoring acceptability is essential.

Conclusion

It is easy to avoid the issue of AIDS and to justify this omission on the basis of the current low heterosexual incidence of AIDS. On a worldwide basis, heterosexual intercourse is the most frequent means of HIV acquisition and is promoted by concurrent STD.[13] We now have the advantage of a wide knowledge of the cause, epidemiology and clinical manifestations of HIV infection and many areas for therapeutic intervention are emerging. This should encourage us to act before a significant heterosexual epidemic occurs. Genitourinary medicine has the necessary experience. Now, following the Monk's report and the Government AIDS initiative, the resources to facilitate our commitment to all aspects of AIDS monitoring, care, prevention and research have been found. Successful implementation of HIV control strategies through genitourinary medicine clinics carries with it the prospect of reduced morbidity from the other pathological consequences of sexual activity—unwanted pregnancy, infertility, debilitating multi-system chronic disease from late STD complications, perinatal infections, and anogenital cancers. Health education to increase personal awareness, developing more screening with patient consent, preparing and giving patients the choice to cooperate in contact tracing as for other STD, are matters of urgency. So long as we continue to reassure patients about our commitment to their confidential care, to remain respectful, compassionate, non-judgemental and apolitical, these difficult issues can be as successfully addressed with HIV/AIDS as they have been with other STD during the past 70 years.

Our opportunities are unique. We dare not miss them.

1 Wigfield AS. Twentyseven years of uninterrupted contact tracing. The Tyneside Scheme. *Br J Venereal Dis* 1972;**48**: 37–50.
2 Rendtorff RC, Curran JW, Chandler RW, *et al.* Economic consequences of gonorrhoea in women: Experience from an Urban Hospital. *J Am Venereal Dis Assoc* 1974;1:40–7.
3 Anonymous. Personal View. *Br Med J* 1986;**296**:1735.
4 Adler MW. A Unique opportunity to upgrade genitourinary medicine. *Br Med J* 1989;**298**:1201–2.
5 *Training in Genitourinary Medicine.* Joint Committee on Higher Medical Training Handbook London. JCHMT 1988.
6 Anonymous. Zidovudine in symptomless HIV infection. *Lancet* 1989;1:425–6.
7 Loveday C, Pomeroy L, Weller IVD, *et al.* Human immunodeficiency viruses in patients attending a sexually transmitted disease clinic in London, 1982–7. *Br Med J* 1989;**298**:419–22.
8 Polakoff S. HIV infection in sexually transmitted disease clinics in England and Wales. *Br Med J* 1988;**298**:415–8.
9 Department of Health. *New cases seen at Genitourinary Medicine Clinics 1987.* London 1989.
10 Adler MW. Epidemiology of HIV infection. *J R Coll Phys* 1988;**122**:133–5.
11 Greenblatt RM, Lurehart SA, Plummer FA, *et al.* Genital ulceration as a risk factor for human immunodeficiency virus infection. *J Aids* 1988;2:47–50.
12 Pepin J, Plummer FA, Brunham RC, *et al.* The interaction of HIV infection and other STD; an opportunity for intervention. *J Aids* 1989;3:3–9.
13 Piot P, Kreiss JK, Ndinya-Achola JO, *et al.* Heterosexual transmission of HIV. *J Aids* 1988;1:199–206.

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